DEPARTMENT OF HEALTH AND HUMA

PRINTED: 09/16/2015 **FORM APPROVED**

CENTER	S FUR MEDICARI	E & MEDICAID SERVICES			OMB NO	. 0938-039
	STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION IN PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER		(X2) MUL A BUILO	TIPLE CONSTRUCTION NG	IX31 OATE SURVEY COMPLETEO	
NAME OF PROVINCE OF SUPPLIES		495409	B WING		08/	C /27/2015
NAME OF PROVIOER OR SUPPLIER ABINGDON HEALTH CARE LLC			STREET AOORESS, CITY, STATE, ZIP COOE 15051 HARMONY HILLS LANE ABINGDON, VA 24212			
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCEO TO TH OEFICIENCY	ON SHOULO BE IE APPROPRIATE	(X5) COMPLETION OATE
E 000	INITIAL COMMEN	Te	F 0	00		

INITIAL COMMENTS

An unannounced Medicare/Medicaid standard survey was conducted 8/25/15 through 8/27/15. Complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.

The census in this 120 certified bed facility was 111 at the time of the survey. The survey sample consisted of 22 current Resident reviews (Residents 1 through 20 and Residents 27 and 28) and 6 closed record reviews (Residents 21 through 26).

F 155 483.10(b)(4) RIGHT TO REFUSE: FORMULATE SS=D ADVANCE DIRECTIVES

> The resident has the right to refuse treatment, to refuse to participate in experimental research. and to formulate an advance directive as specified in paragraph (8) of this section.

The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

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- 1. Advance Directives (DDNR/Golden Rod) for resident # 11 was reviewed and corrected to indicate the resident's capacity to make an informed decision about providing, withholding or withdrawing specific medical treatment or course of treatments and signed by the physician. Resident #11 Advance Directive (DDNR/Golden Rod) was
- 2. Any resident has the potential to be affected if the DDNR is not accurately completed. A 100% audit of residents with DNR orders will be completed to ensure DDNRs in place are accurately completed.

corrected on September 1, 2015.

LABORATORY DIRECTOR'S OR PROVIOER/SUPPLIER REPRESENTATIVE'S SIGNATURE

ministrator

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		AND HUMÁ. SERVICES & MEDICAID SERVICES		(PRINTED: 09/16/2 FORM APPRO' OMB NO. 0938-0	VEC
STATEMENT OF OEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA NO PLAN OF CORRECTION IOENTIFICATION NUMBER:		1, .	ILTIPLE CONSTRUCTION (X3) OATE SURVEY COMPLETED	,	
		495409	B WING	08/27/2015	;
	PROVIOER OR SUPPLIER ON HEALTH CARE LL	.c		STREET AOORESS. CITY. STATE. ZIP COOE 15051 HARMONY HILLS LANE ABINGDON, VA 24212	_
(X4) IO PREFIX TAG	(EACH DEFICIENCY	TEMENT OF OEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFIX TAG	IX (EACH CORRECTIVE ACTION SHOULD BE COMPLET	TION
F 155	Continued From pa	ge 1	F 15	155	
	by: Based on staff inter review the facility st complete a DDNR (order form for 1 of 2 The findings include The DDNR order for	IT is not met as evidenced view and clinical record aff failed to accurately Durable Do Not Resuscitate) 8 Residents, Resident #11.		 Licensed nursing staff, Social Services staff, Admissions staff and Medical staff (Physician/NP/PA) will be educated on the proper execution of DDNR forms indicating resident capacity to consent. Social Services Director or designee will audit the DDNR forms for new admissions weekly for 4 weeks and then monthly for 2 months to ensure 	

Resident #11 was admitted to the facility 08/15/14. Diagnoses included, but were not limited to, hypertension, dementia, depressive disorder, and diabetes.

Section C (cognitive status) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 06/24/15 scored the Resident 4 out of a possible 15 points. The Resident was not interviewable.

The Residents clinical record contained an "Order Summary Report" that included a DNR (Do Not Resuscitate) order. The order date was documented as 08/21/14.

The clinical record also included a copy of the Residents DDNR order form from the Virginia Department of Health. The area on this form for the date had been left blank.

Under section 1 the DDNR read in part, "I further certify [must check 1 or 2]:

1. The patient is CAPABLE of making an informed decision...

- accurate completion. Evidence of noncompliance will be addressed and results will be reported to QA for further discussion and recommendations.
- 5. Completion date: October 8, 2015

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Event IO: SJOI11

Facility IO: VA0406

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PRDVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		405400	B WING		С
1111E OF	SEALMOND ON CHIRDHED	495409	B WING		08/27/2015
NAME OF	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	
ABINGD	OON HEALTH CARE LL	.C		951 HARMONY HILLS LANE BINGDON, VA 24212	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFEDERICIENCY)	D BE COMPLETION
F 157	informed decision The boxes beside # Section 2 read "If you B, or C below:" The been left blank. The administrator, If ADON (assistant directions and the consultant were not order form in a mee 08/26/15 at approximation of the survivided to the survivided to the survivided to the survivided to the survivided (INJURY/DECLINE/	NCAPABLE of making an that and #2 had been left blank. ou checked 2 above, check A, three boxes below had also DON (director of nursing), rector of nursing), and nurse tified of the incomplete DDNR eting with the survey team on mately 11:30 a.m. on regarding this issue was vey team prior to the exit FY OF CHANGES	F 1	Corrective Action	
	consult with the resi known, notify the resi pr an interested fam accident involving the injury and has the po- intervention; a signif physical, mental, or deterioration in health status in either life the clinical complications significantly (i.e., a nexisting form of treat consequences, or to treatment); or a deci	ident's physician; and if sident's legal representative hily member when there is an increase the resident which results in otential for requiring physician ficant change in the resident's psychosocial status (i.e., a th, mental, or psychosocial hreatening conditions or is); a need to alter treatment increase to discontinue an timent due to adverse to commence a new form of ision to transfer or discharge the facility as specified in		Duly noted. Resident #21 was record review. Resident #21 direceive any ill effects from fact failing to notify responsible pasustained 3/26/15 without injut. Other potential residents: Any resident has the potential affected if RP's are not notified.	id not ility staff orty of fall ury. to be

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Event ID: SJDItt

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CENTERS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495409	8 WING		C 08/27/2015
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	
ABINGDON HEALTH CARE LI	LC		15051 HARMONY HILLS LANE ABINGDON, VA 24212	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE COMPLETION DATE
and, if known, the ror interested family change in room or respecified in §483.1 resident rights underegulations as specified this section. The facility must reached the address and phase legal representative. This REQUIREMENT by: Based on staff interested and clinical record ration notify the responsof 28 residents (Resident #21 was a 3/21/15, with diagnoral limited to: hypertens reflux disease, atriat thyroid disorder, and A review of Resident revealed on the most (MDS) with an asset	so promptly notify the resident esident's legal representative member when there is a commate assignment as 5(e)(2); or a change in er Federal or State law or iffied in paragraph (b)(1) of cord and periodically update one number of the resident's or interested family member. AT is not met as evidenced rview, facility document review eview, the facility staff failed isible party (RP) of a fall for 1 sident #21).	F1	DEFICIENCY)	ill be audited s a fall for RP nitor all resident on daily for 4 weeks. ance will be eported to QA
understand and to b assistance with all a Continued review of	e understood. She requires ctivities of daily living (ADL). the residents closed cord revealed the following		·	

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nurses note in part: "3/26/15 23:06; Resident yelling out at this time. Upon on entering room

Even) ID: SJD)11

Facility ID: VA0406

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PRINTED: 09/16/2015 FORM APPROVED OMB NO. 0938-0391

		X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) OATE SURVEY COMPLETEO	
		495409	B WING	i		C 08/27/201	15
	PROVIOER OR SUPPLIER	.c		15051	T AOORESS, CITY, STATE, ZIP COOE HARMONY HILLS LANE GDON, VA 24212	1 00/2//201	
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F 226 SS=8	bed. Assisted into vinjury at this time. " Review of the reside did not reveal notifice on 8/27/15 at 8:15a was asked if she conotification of the RI After researching the of nurses replied." Prior to exit on 8/27 provided to the survinotify the RP. 483.13(c) DEVELOI ABUSE/NEGLECT, The facility must deep olicies and proceder mistreatment, negleand misappropriation. This REQUIREMEN by: Based on staff interreview, and employed failed to follow their screening of new enterprise of the facility was unally t	ting in her floor beside of her w/c (wheel chair), no noted ents electronic clinical record cation of the RP. em, the director of nurses uld locate documentation of P related to the 3/26/15 fall. e clinical record the director couldn't find the notification. /15 no further information was reyor related to the failure to P/IMPLMENT ETC POLICIES velop and implement written ures that prohibit ct, and abuse of residents no fresident property. IT is not met as evidenced eview, facility document record review, the facility policy and procedure for the imployees for 5 of 5 new hires.			226 Corrective Action 5 of the 5 new hires identified during survey have had refechecks initiated. New hire # license verification completed during survey.	rences 3 had	

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E & MEDICAID SERVICES			OMB NO. 0938-0391
(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1		(X3) OATE SURVEY COMPLETED
495409	B WING		C 08/27/2015
3	<u> </u>	STREET AOORESS CITY, STATE, ZIP C	OOE
LC		15051 HARMONY HILLS LANE ABINGDON, VA 24212	
ATEMENT OF DEFICIENCIES OF MUST BE PRECEOEO BY FULL LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A OEFICIENCY)	SHOULD BE COMPLETION
age 5 re verification for an LPN nurse) until the time of the urveyor reviewed 5 new hire urveyor reviewed 5 new hire uployee records included When HR (human resource) asked about the reference she had only been employed short while and was unable to checks. was an LPN, was hired at the the facility did not verify the until the time of the survey asked about the license ployee #1 verbalized to the had checked the employee had been requested by the r and when she noticed the was not in the employee file ensed. procedure titled "Hiring n, Employee Records, Ferminations" read in part. k all references before er. (Two (2) references everification Verify the license Virginia Department of Health the the hire date" DON (director of nursing), irrector of nursing), and nurse tified of the above in a meeting	F 22	2. Any resident has the affected if screening not completed. Curr records will be auditoreference checks obtormer employer prolicense verifications of the Hiring Process Employee Records, Rand Terminations poregulatory requirement. 4. HR Generalist or desemployee records of weekly for 3 months the facility Administr Committee and QA Creview and oversight. 5. Completion date 2015	of new hires is rent employee ed to ensure tained to extent ovides and on file. an Resources yed education s, Evaluation, Resignations olicy and ents. signee will audit finew hires and submit to rator, Safety Committee for t.
The second of th	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495409 LC ATEMENT OF DEFICIENCIES YMUST BE PRECEOEO BY FULL LSC IDENTIFYING INFORMATION) age 5 be verification for an LPN nurse) until the time of the urveyor reviewed 5 new hire apployee records included When HR (human resource) asked about the reference she had only been employed short while and was unable to checks. As an LPN, was hired at the the facility did not verify the until the time of the survey asked about the license poloyee #1 verbalized to the had checked the employee had been requested by the rand when she noticed the was not in the employee file ensed. Tocedure titled "Hiring in, Employee Records, Ferminations" read in part. It is all references before ear. (Two (2) references before ear. (Two (3) references before ear. (Two (4) references before ear. (Two (5) references before ear. (Two (6) references befor	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIA BUILDI 495409 B WING LC ATEMENT OF DEFICIENCIES (YMUST BE PRECEDED BY FULL ISC IDENTIFYING INFORMATION) TAG age 5 F 27 e verification for an LPN nurse) until the time of the unveyor reviewed 5 new hire Inployee records included (When HR (human resource) asked about the reference she had only been employed short while and was unable to checks. Was an LPN, was hired at the the facility did not verify the until the time of the survey asked about the license ployee #1 verbalized to the lad checked the employee had been requested by the rand when she noticed the was not in the employee file ensed. Forcedure titled "Hiring (IN) (IN) (IN) (IN) (IN) (IN) (IN) (IN)	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER: 495409 B WING STREET ADORESS CITY, STATE, ZIP C 15051 HARMONY HILLS LANE ABINGDON, VA 24212 ATEMENT OF DEFICIENCIES IN MUST BE PRECEOED BY FULL USC IDENTIFYING INFORMATION) age 5 e verification for an LPN nurse) until the time of the urveyor reviewed 5 new hire apployee records included When HR (human resource) asked about the reference she had only been employed short while and was unable to checks. vas an LPN, was hired at the the facility did not verify the until the time of the survey saked about the license looyee #1 verbalized to the rand when she noticed the was not in the employee file rand when she noticed the was not in the employee file resed. rocedure titled "Hiring n, Employee Records, ferminations" read in part. call references before ear. (Two (2) references Verification Verify the license Verification number: ABINGDON, VA 24212 PROVICETS PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED to THE ABINGDON, VA 24212 2. Any resident has the affected if screening not completed. Curr records will be audit reference checks obt former employer pro license verifications of the survey saked about the license on the Hiring on th

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approximately 11:30 a.m.

with the survey team on 08/26/15 at

Event ID: SJOI11

Facility IO: VA0406

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DEPARTMENT OF HEALTH AND HUMA SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER.	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495409	B WING		C 08/27/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	
ABINGD	ON HEALTH CARE LI	_C		15051 HARMONY H(LLS LANE ABINGDON, VA 24212	·
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE COMPLETION
F 226	Continued From pa	ge 6	F 22	26	
	provided to the survice conference. 483.20(g) - (j) ASSE ACCURACY/COOF The assessment mirresident's status. A registered nurse reach assessment with participation of health and the session of the assessment is complete to a civil most provided	RDINATION/CERTIFIED ust accurately reflect the must conduct or coordinate vith the appropriate th professionals. must sign and certify that the pleted. completes a portion of the ign and certify the accuracy of	F 27	Corrective Action: Resident #4 has since had assessment 8/18/15, which pain status in Section J (He and Resident #4's clinical rupdated to reflect the current Resident #10's clinical recomposed with a current BIN resident's current cognitive #1's MDS was modified an CMS on 8/25/15 to include resident on Section O. Resinterviewed to reflect current Resident #23's MDS was more resubmitted to CMS on 8/25 hospice while a resident of Resident #13's clinical recomposed to reflect the current height	h reflected current ealth Conditions) record was rent height. ord has been MS to reflect restatus. Resident resubmitted to redialysis while a rident #7 has been rent pain status. The diffied and 26/15 to include on Section O.
	Clinical disagreement material and false st	nt does not constitute a catement.		3	
	This REQUIREMEN	T is not met as evidenced			,

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by:

Event ID: SJDI11

Facility (D: VA0406

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV	DEPAR	RTMENT OF HEALTH	ERVICES I AND HUMA		1	FORM APPROV	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING C 495409 B. WING 08/27/20	CENTE	ERS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-03	
495409 B. WING 08/27/20				1 ' '		(X3) DATE SURVEY COMPLETED	
			495409	B. WING		•	
ABINGDON HEALTH CARE LLC 15051 HARMONY HILLS LANE ABINGDON, VA 24212	1		_C		15051 HARMONY HILLS LANE		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	PRÉFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREF	X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE COMPLETION	ОИ
F 278 Continued From page 7 Based on staff interview, and clinical record review, the facility staff failed to ensure an accurate Minimum Data Set (MDS) assessment for 6 of 28 residents (Resident #4, #10, #1, #7, #23, and #13). The findings include: 1. The facility staff failed to ensure an accurate MDS assessment for Resident #4. Resident #4 was admitted to the facility on 7/29/13 with diagnoses of arthritis, seizure disorder, anxiety, insomnia, depression, diabetes, stroke, bipolar disorder, and hypertension. The current annual MDS with a reference date of 5/21/15 assessed the resident with a cognitive score of "15". The resident was assessed requiring extensive assistance of 1 person for bed mobility, transfers, dressing, toileting, F 278 Other potential residents: Any resident has the potential to be affected if MDS sections C, J, K and O are inaccurately coded Systemic changes: MDS nurses have received education from the state CMS RAI training manual on how to correctly evaluate and code Sections J, K and O of the MDS. MDS nurses and Dietary Managers have received education from the state CMS RAI training manual on how to correctly evaluate and code Section K of the MDS. MDS nurses and Social Services have	F 278	Based on staff intereview, the facility saccurate Minimum for 6 of 28 residents #23, and #13). The findings include 1. The facility staff f MDS assessment for MDS assessment for Resident #4 was accorder, anxiety, in stroke, bipolar disorder, anxiety, in stroke, bipolar disorder annual MDS 5/21/15 assessed the score of "15" of "15" requiring extensive	rview, and clinical record staff failed to ensure an Data Set (MDS) assessment is (Resident #4, #10, #1, #7, e: ailed to ensure an accurate or Resident #4. Imitted to the facility on sess of arthritis, seizure somnia, depression, diabetes, ider, and hypertension. The ider resident with a cognitive in the resident was assessed assistance of 1 person for	F 2	Other potential residents: Any resident has the potential if MDS sections C, J, K and O a coded Systemic changes: MDS nurses have received exthe state CMS RAI training m correctly evaluate and code SO of the MDS. MDS nurses at Managers have received edustate CMS RAI training manu correctly evaluate and code SO	ducation from nanual on how to Sections J, K and nd Dietary ucation from the ual on how to Section K of the	

Section "J" for Health Conditions was reviewed. Section J0200 noted the pain assessment should be conducted. The resident and staff interviews related to pain were not completed and each question was marked with a dash (-).

Section "K" for Swallowing/Nutritional Status was reviewed for the MDS completed on 10/8/14 and 1/2/15. The 10/8/14 MDS noted the resident to be 67 inches tall. The following MDS assessment noted the resident to be 55 inches tall.

The MDS coordinator (RN#2 was interviewed on 8/26/15 at 10:20 a.m. and the MDS inaccuracies. RN#2 stated the resident must not have been available for the pain assessment.

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training manual on how to correctly evaluate

and code Section C of the MDS. Clinical staff

to be educated on the facility's policy and

procedure for obtaining heights

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	OMB NO. 0938-0				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	į	495409	B WING			C 08/27/2015	
	PROVIDER OR SUPPLIER ON HEALTH CARE LL	.c		15051	ET ADDRESS, CITY, STATE, ZIP CODE 1 HARMONY HILLS LANE JGDON, VA 24212	1 0012112013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLÉTI	ION
	director of nursing, informed of the find survey team on 8/26 2. The facility staff MDS assessment in Resident #10. Resident #10 was a 3/25/15 with diagno hypertension, bipola atrial fibrillation. The admission MDS 4/1/15 did not conta Cognitive Patterns. (-). The MDS coordinate 8/25/15 at 4:00 p.m. RN#2 stated the resident #10 administrator, of director of nursing, a informed of the finding survey team on 8/26 3. For Resident #1, the Residents dialys	director of nursing, assistant and corporate nurse were ings during a meeting with the 6/15 at 4:00 p.m. failed to ensure a completed related to cognition for admitted to the facility on ses of dementia, insomnia, ar disorder, hip fracture, and a completed Section "C" for All areas contained a dash or (RN#2 was interviewed on and the MDS inaccuracies sident must not have been gnitive assessment.	F2		Monitoring: MDS nurses or designee will a for 12 residents weekly for 4 monthly for 2 months. Social designee will monitor MDS Seresidents weekly for 4 weeks, for 2 months. MDS nurses or monitor MDS Section O for al receiving dialysis weekly for 4 monthly for 2 months. Unit records for presence and acceptable will monitor new addressed for 4 weeks, then months. Evidence of non-commonths. Evidence of non-commonths. Evidence of non-commonths and recommendations.	weeks, then I Services or ection C for 12 , then monthly designee will II residents 4 weeks, then managers or Imission uracy of heights nthly for 2 npliance will be	
	Diagnoses included,	mitted to the facility 02/18/13. but were not limited to, end bipolar disorder, depression, and hypertension.			This plan will be effective on (2015.	October 8,	ļ

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Section C (cognitive patterns) of the Residents

Event (D: SJD)11

Facility ID: VA0406

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DEPARTMENT OF HEALTH AND HUMAN JERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	OMB NO. 0938-03					
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A BUILD		CONSTRUCTION		ATE SURVEY OMPLETED	
		495409	B WING			0:	C 8/27/2015	
NAME OF	PROVIDER OR SUPPLIER		·	ST	REET ADDRESS. CITY. STATE, ZIP CODE	!		
ABINGD	ABINGDON HEALTH CARE LLC				051 HARMONY H(LLS LANE BINGDON, VA 24212			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLET(ON OATE	
F 2 7 8	Continued From pa	ge 9	F 2	278				
	significant change I assessment was so points. Section O (s procedures, and pro-	MDS (minimum data set) cored 9 out of a possible 15		-				
	The Residents "Order Summary Report" included an order for HD (hemodialysis) on Monday, Wednesday, and Fridays.							
	(registered nurse) #	roximately 2:25 p.m. RN £1, who was the MDS nurse, e coding on the MDS						
	verbalized to the su	roximately 2:55 p.m. RN #1 rveyor that she had completed as the Residents dialysis had the MDS.						
	ADON (assistant di							
	provided to the surviconference. 4. For Resident #7,	on regarding this issue was yey team prior to the exit the facility staff failed to ssessment portion of the a set).						
	08/24/12 and readmincluded but not limit failure, hypertension	mitted to the facility on nitted on 01/30/15. Diagnoses ited to congestive heart n, hyperlipidemia, cident, hemiplegia, anxiety,						

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depression, chronic obstructive pulmonary

Event ID: SJDI11

Facility ID: VA0406

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PR(NTED: 09/16/2015 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391		
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .		CONSTRUCTION		ATE SURVEY OMPLETED
		495409	8 WING			Of	C 8/ 27/201 5
	PROVIDER OR SUPPLIER ON HEALTH CARE LI	c		150	EET ADDRESS, CITY, STATE, ZIP CODE 51 HARMONY HILLS LANE INGDON, VA 24212		0/21/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 278	gastroesophageal r artery disease.	lney disease, atrial fibrillation, eflux disease, and coronary	F 2	78			
	(assessment refere the Resident as a 1 patterns. Section J, as a "1" under pain equivalent of "receiv medication". Subse Assessment Interview	arterly MDS with an ARD nce date) of 08/06/15 coded 2 of 15 in section C, Cognitive Health Conditions was coded management, which is the yed scheduled pain ction J0200, "Should Pain ew be Conducted?" was a pain assessment interview					
w F cc pe	contained a problen	(comprehensive care plan) n which read in part "has a neuropathy/history of pints"					·
	08/26/15 at approximation	th the administrative staff on mately 1130, the missing ought to their attention.					
7 0 r s	08/26/15 at approximissing assessmen	with the MDS coordinator on nately 1330 regarding the t. The MDS coordinator dent had been out of the n the ARD date.					
	08/2/15 at approxim missing pain assess	ith the administrative staff on ately 1630, the concern of the ment was discussed. ailed to code when Resident hospice on 5/1/15.					
		f Resident #23 was reviewed Resident #23 was admitted				,	

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to the facility initially 12/29/14 and readmitted

Even| ID: SJDI11

Facility ID: VA0406

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		AND HOMAN SERVICES			S	FOR	MAPPROVED	
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB N	O. 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MUL A BUILD			(X3) DATE SURVEY COMPLETED		
		495409	B WING		7	0.	C 8/27/2015	
NAME OF	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		3.21,2010	
ABINGDON HEALTH CARE LLC					51 HARMONY HILLS LANE NGDON, VA 24212			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	IX5I COMPLETION OATE	
F 278	were not limited to a chronic kidney disepain, pressure ulcer hypertension, esoph Resident #23's sign minimum data set (assessment referenceded the resident mental status (BIMS). Resident #23 was a hospice on 5/1/15. with ARD of 5/14/15 evidence. Section (Procedures, and Procedures, an	23's diagnoses included but debility, atrial fibrillation, ase, diabetes mellitus, acute r, edema, hyperlipidemia, nageal reflux, and anxiety. ificant change in assessment MDS) assessment with an ice date (ARD) of 5/14/15 with a brief interview for as 14 out of 15. Idmitted to the services of The significant change MDS add not address this D Special Treatments, ograms Part K. Hospice Care marked to indicate that ospice services. I weed registered nurse #1 on concerning the inaccurate She acknowledged Resident for hospice dated 5/1/15 and the been marked on the MDS. I we determine the inaccurate she assistant director of porate registered nurse of the 16/15 at 4:30 p.m.	F 2	78				

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date) of 5/13/15.

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Facility ID: VA0406

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DEPARTMENT OF HEALTH AND HUMA, . SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/16/2015 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				MB NO. 0938-0391
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUI A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495409	B. WING			C
NAMEOF	PROVIDER OR SUPPLIER				FCT ADDDESS OF STATE AND STATE	08/27/2015
	ON HEALTH CARE LL	.c		1505	EET ADDRESS. CITY. STATE. ZIP CODE 51 HARMONY HILLS LANE NGDON, VA 24212	
				ADI	NGDON, VA 24212	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 278	Continued From pag	ae 12	F2	78		
	Resident #13 was o on 5/4/15. Her diagr limited to: high blood Parkinson 's diseas osteopprosis. The initial minimum with an assessment	riginally admitted to the facility nosis included, but was not d pressure, diabetes, e.e., bi-polar, anxiety, and data set assessment (MDS) reference date (ARD)	1 2	7.0		
	surveyor observed t	15 for Resident #13. The hat Section k, had a dash In section K the dash mark or height.				
	2:55pm, and asked have been documenthe MDS was done to nursing assessment should have been do she said. "I agree it assessment." Further review of the revealed in the section Resident #13's weither the section of the	s interviewed on 8/26/15 at if section k for height should atted. She responded when the height was not in the . When asked if the height ocumented on the initial MDS a should have been on the eresident's clinical record on for weight on 5/8/15, ght was 160. The weight was linical record prior to the ARD				
	On 8/26/15 the admit of the undocumented initial MDS. Prior to exit on 8/27/information was provite the undocumented					·
	483.20(k)(3)(i) SERV PROFESSIONAL ST	/ICES PROVIDED MEET ANDARDS	F 2	31	Corrective Action:	
		ed or arranged by the facility nal standards of quality.			Physician order was obtained o 26 for Resident #6's self-releasi	

belt with chair alarm.

DEPARTMENT OF HEALTH AND HUMA.

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		I AND HOMAL SERVICES			FORM APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
	T OF OFFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULT A. BUILOII	TIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
	- <u></u>	495409	B. WING _		C 08/2 7/2015
NAME OF	PROVIOER OR SUPPLIER			STREET AOORESS, CITY, STATE, ZIP COOE	
ARINGD	ON HEALTH CARE LL	10		15051 HARMONY HILLS LANE	
	JIV HEREIT, STATE II			ABINGDON, VA 24212	
(X4) IO PREFIX TAG	(EACH OEFICIENCY	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCEO TO THE APPROPRICED TO THE APPRO	JLO BE COMPLETION
F 281	Continued From pa	ige 13	F 28	Other potential residents	:
l •	~			Any resident has the pote	ntial to be
		NT is not met as evidenced		affected if physician order	
	by: Based on staff inte	rview, facility document		obtained for self-releasing	
		record review, the facility staff		and personal alarms. A 10	·
		rofessional standards of		residents with self-releasi	
	<u> </u>	1 of 28 residents (Resident		and safety alarms will be o	- I
	#6).				
	The findings include	3 ;		ensure a physician order is	s in place for
		1. 6.6.9 1		use of the safety device.	
		ed to obtain a physician order seat belt with a chair alarm for		Systemic changes:	
	Resident #0.			Licensed nurses will be ed	ucated on the
		of Resident #6 was reviewed		nursing standard of practic	ce and facility
		5. Resident #6 was admitted		policy to obtain physician	· 1
	but not limited to dw pressure ulcer sacre	with diagnoses that included varfism, paraplegia, stage 4 um, chronic obstructive		safety devices.	
				Monitoring:	
	antiooagaianto, ana	пурокаютна.		Unit Managers, Nursing Su	pervisors or
		erly minimum data set (MDS)		designee will monitor the	
		n assessment reference date		report for any new safety	
		sessed the resident with a score of 15 out of 15.		ordered daily (M-F) for 4 w	l i
	Cognitive summer;	30016 01 10 001 01 10.		weekly for 8 weeks, and er	
		iewed Resident#6 on 8/25/15		physician order is in place	
		ent #6 was sitting in a		record. Evidence of non-co	
•		sident's room watching eyor observed a clip alarm		will be addressed and resu	
		elchair. Resident #23			
	informed the survey	or he had a seat belt around		reported to QA for further	discussion
	his waist that he cou	uld easily remove. He stated		and recommendations.	į l

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he liked the seat belt because he had had

multiple falls from his wheelchair in the past.

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Facility IO: VA0406

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Completion date: October 8, 2015.

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	TMENT OF HEALTH RS FOR MEDICARE	AND HUMA . JERVICES		(FORM	D: 09/16/2015 MAPPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495409	B. WING _		90	C 3/27/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		<u> </u>
ABINGD	ON HEALTH CARE LL	.c		15051 HARMONY HILLS LANE ABINGDON, VA 24212		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 281	Continued From page	ge 14	F 28	! 1		
	2015 electronic phy	wed Resident #6's August sician orders. The surveyor orders for the use of the self				
	the director of nursir registered nurse on stated a physician of	ssed the use of a seatbelt with ng and the corporate 8/26/15 at 4:15 p.m. Both order was needed for the use stated they would expect the s for the seat belt.				
	director of nursing, to nursing, and the cor above finding on 8/2 requested the facility	ned the administrator, the the assistant director of rporate registered nurse of the 26/15 at 4:30 p.m. and y's standard of nursing g and writing physician				
	the facility standard 8/27/15 at 8:45 a.m. Federal and State R (verbal) orders may nurse or licensed ST	ing provided the surveyor with of practice for orders on . The policy read "Orders Regulations 2. Telephone only be given to a licensed T, OT, or PT at the facility.				

No further information was provided prior to the exit conference on 8/27/15.

podiatrist, nurse practitioner or physician assistant, licensed to prescribe in Virginia."

F 312 483.25(a)(3) ADL CARE PROVIDED FOR SS=D DEPENDENT RESIDENTS

A resident who is unable to carry out activities of daily living receives the necessary services to

F 312 Corrective Action:

Resident #9 provided nail care by unit manager on 8/26/15.

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			0	FORM APPROVED 0MB NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PRDVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	1	TIPLE CONSTR	RUCTION	(X3) DATE SURVEY COMPLETED
		495409	B WING			C 08/27/2015
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET AD	DRESS, CITY, STATE, ZIP CODE] 00/21/2015
ABINGD	ON HEALTH CARE LI	.c			RMONY HILLS LANE DN, VA 24212	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD DSS-REFERENCED TO THE APPROPROPROPROPERTY)	BE COMPLETION
F 312	Continued From pa	ge 15	F 3 ²	12		
	maintain good nutri and oral hygiene.	tion, grooming, and personal			her potential residents:	; ;
				An	y resident has the potential	I to be
				aff	ected if nail care is not prov	vided. A
		NT is not met as evidenced		10	0% audit will be conducted	to
	record review, the fa	ion, staff interview and clinical acility staff failed to provide residents (Resident #9).		ide car	entify residents who are nee re.	ed of nail
	The findings include	: :				•
	The facility stoff fails	ad to provide pail core for		Sys	stemic changes:	:
	Resident #9.	ed to provide nail care for		Nu	rsing staff will be educated	regarding
					licy and procedure relating	
	6/30/13 and readmit	mitted to the facility on tted on 6/7/15 with diagnoses es, hypertension, stroke, hip		cai	· · · · · · · · · · · · · · · · · · ·	to han
	The quarterly Minim reference date of 7/4	ation, anxiety, and anemia. Jum Data Set (MDS) with a 4/15 assessed the resident		M	lonitoring:	:
		re of "4" of "15". The resident ring extensive assistance of		Un	nit managers or designee wi	ll perform
	1-2 persons for bath	ling, hygiene, eating, toileting,			ndom monitor of ten reside	· ·
	bed mobility, and tra	insfers.			il care daily for 4 weeks, we	
	The resident was ob	served on 8/26/15 at 7:45			eeks, and then monthly for :	•
	a.m. sitting in the dir	ning area. The resident was			idence of non-compliance v	1
	were observed to be jagged edges and de	shaven. The resident's nails e long and unclean with ark debris under the nails on		ad	dressed and results reporte mmittee.	
	3:30 p.m. The unit m	served in bed on 8/26/15 at nanager(RN#3) accompanied ked the resident to show his			is plan will be effective on 0	October 8,

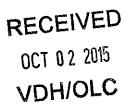
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hands. The resident was clean shaven and hair was damp at this time. The resident showed his

Event (D: SJD) (1

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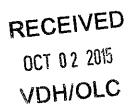
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		495409	B WING		C 08/27/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	
ABINGD	ON HEALTH CARE LL	.c		15051 HARMONY HILLS LANE ABINGDON, VA 24212	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLETION
F 312	Continued From pa	ge 16	F 3	12	
	hands and again the	e nails were observed long ebris under the nails. RN#3			
	evidence of bathing	e was asked and provided for Resident #9. The report resident had received a on 8/26/15.			
	director of nursing, a informed of the find survey team on 8/26	lirector of nursing, assistant and corporate nurse were ings during a meeting with the 6/15 at 4:00 p.m. ENT/CARE FOR SPECIAL	F 32	Mary Law 1-	
	The feetile	and the second second		Corrective Action:	
		sure that residents receive d care for the following		Resident # 22 duly noted. Res	sident # 22 was
	Injections; Parenteral and ente Colostomy, ureteros Tracheostomy care;	tomy, or ileostomy care;		a closed record review.	
	Tracheal suctioning; Respiratory care;			Other potential residents:	
	Foot care; and Prostheses.			Any resident has the potential pulse oximetry is not obtained as ordered. A 100% audit of re	l and documented
	This REQUIREMEN	T is not met as evidenced		pulse oximetry monitoring wil	
	by:			ensure compliance with physic	
		view and clinical record aff failed to obtain physician			
		try every shift for 1 of 28		Licensed nurses will be educat	
	residents (Resident			standard of care and procedur	e for following
	The findings include			physician orders for pulse oxin and documentation	

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Eveni (O: SJD[11

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	AND HOMAN SERVICES			FORM APPROVED
CENTERS FOR MEDICARE	& MEDICAID SERVICES		(DMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
	495409	B. WING		C 08/27/2015
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/2/12/10
ABINGDON HEALTH CARE LL	.c		15051 HARMONY HILLS LANE ABINGDON, VA 24212	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION
pulse oximetries for The clinical record of 8/26/15 and 8/27/15 to the facility 1/26/1 but not limited to fal osteoarthrosis, mus insomnia, edema, a congestive heart fai reflux, hypopotasse Resident #22's adm (MDS) assessment reference date (ARI resident with a cogn of 15. Resident #22 extensive assistance mobility, transfers, opersonal hygiene. Fassistance of 1 pers Resident #22's rang impairment in either the lower extremity impairment on one scontinence revealed incontinent of both. The comprehensive created on 2/20/15 for "Resident #22 has CHTN (hypertension) ability, comfort and continent and continent of the comprehensive created on 2/20/15 for "Resident #22 has CHTN (hypertension) ability, comfort and continent	ed to obtain physician ordered	F 32	Monitoring: Unit Managers, Nursing Supervise will review the TARs for residents ordered pulse oximetry monitoring for 4 weeks and weekly for 8 weeks compliance. Evidence of non-combe addressed and results will be a for further discussion and recommendate. This plan will be effective on October 1.	with physician ng daily (M-F) eks to ensure npliance will reported to QA mendations

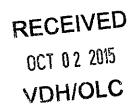
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and report to MD as indicated s/sx (signs and symptoms) of Congestive Heart Failure: dependent edema of legs and feet, periorbital edema, SOB (shortness of breath) upon exertion,

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					MAPPROVED D. 0938-0391
STATEMEN	T OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUL A. BUILO		CONSTRUCTION	(X3) DA	ATE SURVEY OMPLETEO
		495409	B. WING			08	C 3/27/2015
NAME OF	PROVICER OR SUPPLIER			ST	REET AOORESS, CITY, STATE, ZIP COOE		
ABINGD	ON HEALTH CARE LI	_c			051 HARMONY HILLS LANE BINGDON, VA 24212		
(X4) IO PREFIX TAG	(EACH OFFICIENCY	TEMENT OF OEFICIENCIES 'MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG	<	PROVIOER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCEO TO THE APPRO OEFICIENCY)	LO BE	(X5) COMPLETION OATE
F 328	cool skin, dry cough weakness, weight gerackles and wheez lungs, orthopnea, wincreased heart rate. The March 2015 ph was reviewed. The pulse oximetry q (expecessary)." The surveyor review 2015 electronic treat (eTAR). The March when there was no had been obtained: 3/5/15, 3/14/15, 3/2/10. One omission was evening shift. The pulse oximetries had been dates listed in the notates did not reveal oximetries had been dates listed in the notates and vitals summary oximetries had been oximetry had not been 3:00 p.m. The corporatives did work 12 is check to see if this vitals summary oximetry had not been surveyor informatives of the above oximetry had not been surveyor informatives oximetry had not been surveyor informatives oximetry had not been surveyor informatives oximetry had not bee	n, distended neck veins, rain unrelated to intake, res upon auscultation of the reakness and/or fatigue, e., lethargy and disorientation." ysician order sheet (POS) physician order read "Check very) shift and prn (whenever ved Resident #22's March the threat administration record 2015 eTAR revealed shifts evidence the pulse oximetries Day shift3/3/15, 3/4/15, 20/15, 3/22/15, and 3/29/15. Evident on 3/28/15 on the progress notes from 3/1/15 re reviewed. The progress evidence the pulse obtained as ordered on the ote. Yed the weights and vitals 2015. The electronic weights had no evidence the pulse obtained as ordered. ed the corporate registered dates/shifts when the pulse en obtained on 8/26/15 at orate R.N. stated some nour shifts and she would	F 3;	28			

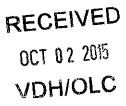
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director of nursing, the corporate registered nurse, and the regional MDS nurse of the failure

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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OHIVI L	NO I ON MEDICANE	- A MEDICAID SERVICES				<u> </u>
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) OATE SURVEY COMPLETED
		495409	B. WING	i		C 08/27/2015
NAME OF	PROVIOER OR SUPPLIER		 -	STF	REET ADORESS, CITY, STATE, ZIP CODE	1 00/21/2010
				[051 HARMONY HILLS LANE	
ABINGD	ON HEALTH CARE LI	_C		l	SINGDON, VA 24212	
	CUMMADVETA	TENENT OF OFFICIENCIES			······································	
(X4) IO PREFIX TAG	(EACH DEFICIENCY	TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE COMPLETION
F 328	Continued From pa	ge 19	Ε,	328		
			' '	120		
•	oximetries on 8/27/	ain physician ordered pulse 15 at 9:15 a.m.				
	No further information	on was provided prior to the		•		-
F 360		VE DEVICES - EATING	- -	369		
	EQUIPMENT/UTEN		Г	109		
		ovide special eating equipment dents who need them.			Corrective Action:	
					Resident #12 duly noted	
	This REQUIREMEN	IT is not met as evidenced			Resident #12's maroon spoon o	order was
	by:				reviewed and revised.	Tuel Was
	Based on observati	ion, staff interview, and clinical			reviewed and revised.	
	physician ordered a	acility staff failed to ensure daptive equipment was			Other potential residents:	
		ring a breakfast meal for 1 of			Any resident has the potential to	o be
	28 Residents, Residents				affected if physician orders are i	not followed
		provide the Resident with			for feeding equipment.	noctonowed
		red "Small maroon spoon."			.A 100% audit of the electronic r	medical
		dmitted to the facility			record of current residents with	
		s included but were not a, dementia, congestive heart			opting utopolic and and all the	therapeutic
	failure, psychosis, a				eating utensils ordered will be co	
		patterns) of the Residents			ensure accuracy; corresponding	
		mum data set) assessment			will be audited to ensure type of	f adaptive
		sment reference date) of			equipment is identified.	•
		1/1/3 to indicate the				'
	Resident had proble	ms with long and short term				
		verely impaired in cognitive				
		on making. Section G0110.H.				
		3/2 to indicate the Resident				
		ssistance of one person.				
		al record included an "Order				
		at had been signed by the				
	rive (lamily nurse pr	ractitioner) 08/04/15. This				

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Event IO: SJQI11

Facility IO: VA0406

If continuation sheet Page 20 of 32

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PRINTED: 09/16/2015 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			C	MB NO. 0938-	-0 391
	IT OF DEFICIENCIES OF CORRECTION	IX1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			CONSTRUCTION	JX3) DATE SURVEY COMPLETED	
		495409	B. WING		(- 	C 08/27/201	15
NAME OF	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		<u></u>
ABING	OON HEALTH CARE LI	-c			951 HARMONY HILLS LANE BINGDON, VA 24212		
(X41 ID PREFIX TAG	JEACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION IEACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLI	
F 369	"small maroon spool on 08/26/15 at app surveyor observed assistant) #1 assist breakfast meal. The using a regular size Resident. The surve Residents meal ticket inclindicate the Reside spoon" at meals. The surveyor asked small maroon spool surveyor that "They C.N.A. #1 continued the large silver spool on 08/26/15 at appisurveyor interviewe The DM was asked maroon spoon. The surveyor the type of stated that the spool placed on the cart, at the meals. The administrator, It ADON (assistant directionsultant were not with the survey team approximately 11:30 assistant of the surveyor that the survey team approximately 11:30 assistant directionsultant were not the survey team approximately 11:30 assistant directionsultant were not the survey team approximately 11:30 assistant directions.	ort included an order for a on with all meals." roximately 8:10 a.m. the C.N.A. (certified nursing ing Resident #12 with their e surveyor observed C.N.A. #1 desilver spoon to feed the eyor was able to observe the et lying on the dining table. Indeed documentation to not was to use a "small maroon of C.N.A. #1 about the missing of C.N.A. #1 verbalized to the don't always give it to us." If to feed the Resident using on. Toximately 9:30 a.m. the dothe DM (dietary manager), about the Residents small DM was able to show the spoon the Resident used and in would have been wrapped, and sent out to the unit with DON (director of nursing), and nurse fied of the above in a meeting in on 08/26/15 at	F3	369	Systemic changes: Nursing staff will be educate process for order entry of acception and meal card refor adaptive feeding equipmed Dietary staff will be educate process for identifying reside physician ordered adaptive equipment and ensuring the is available for use. Monitoring: Unit Managers and Dietary I designees will make random observations at alternating redaily for 4 weeks, weekly for and monthly for 1 month to therapeutic feeding equipmed available and being used as exidence of non-compliance addressed and results will be	daptive ecognition nent. d on the ents with feeding e equipment Manager or meal meal times 4 weeks ensure ent is ordered. will be	
	provided to the surv conference. 483.60(b), (d), (e) D	ey team prior to the exit	F 4	31	Corrective Action:		
		ploy or obtain the services of			LPN #1 was provided educat Medication Storage policy.	ion on the	

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Event ID: SJDI11

Facility ID: VAD406

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PRINTED: 09/16/2015

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495409	B. WING		C 08/27/2015
NAME OF	PROVIDER OR SUPPLIER		·	STREET ADDRESS. CITY, STATE, ZIP CODE	1 00/2//2010
ABINGE	OON HEALTH CARE LI	_C		15051 HARMONY HILLS LANE ABINGDON, VA 24212	
(X41 ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD RF COMPLETION
F 431	of records of receip controlled drugs in a accurate reconciliat records are in order	ge 21 cist who establishes a system t and disposition of all sufficient detail to enable antion; and determines that drug r and that an account of all maintained and periodically	F 4:	Any resident has the poten affected if the medication of locked and attended during pass and pour.	art is not
	Drugs and biologica labeled in accordan professional principl appropriate accessor instructions, and the applicable. In accordance with a facility must store allocked compartmen	State and Federal laws, the ldrugs and biologicals in ts under proper temperature only authorized personnel to		Systemic Changes: Licensed nurses will be edu Medication Storage policy t locking the medication cart leaving it unattended durin pass and pour.	hat includes and not
	permanently affixed controlled drugs liste Comprehensive Dru Control Act of 1976 abuse, except when package drug distrib quantity stored is mi be readily detected. This REQUIREMENT	ovide separately locked, compartments for storage of ed in Schedule II of the g Abuse Prevention and and other drugs subject to the facility uses single unit outlon systems in which the inimal and a missing dose can		Monitoring: Unit Managers, Nursing Supdesignee will observe medicand pour of nurses on alternally (M-F) for 4 weeks, weeks and monthly for 1 weeks and monthly for 1 weeks and results will be to QA for further discussion recommendations.	cation pass nating shifts ekly for 4 eek. e will be e reported
		on, staff interview and facility e facility failed to ensure a		Completion date: October 8	3, 2015

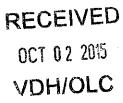
FORM CMS-2567(D2-99) Previous Versions Obsolete

medication cart was locked when not attended for one of three units in the facility, Highland Lane

Event (D: SJD)11

Facility ID: VA0406

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PRINTED: 09/16/2015 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES). 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A BUILD		ONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495409	B WING			0.0	C
NAME OF	PROVIDER OR SUPPLIER		٠		ET ADDRESS. CITY, STATE, ZIP CO	1 0g	/27/2015
	ON HEALTH CARE LL	c		1505	1 HARMONY HILLS LANE NGDON, VA 24212	,,,,,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORF IEACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	IXS COMPLETION DATE
F 431	Continued From page (dementia unit).	ge 22	F 4	31			
	The findings include	ed:					
	unattended by the n	was left unlocked when urse during a medication rvation on the dementia unit.					;
	observed LPN #1 du pour. LPN #1 prepa went to the Residen LPN #1 failed to loci	roximately 0800, the surveyor uring a medication pass and red the medications, and then it's room to administer them. It's the medication cart when to enter Resident rooms.					
	#1 if he could see th Resident rooms whi medication and he s Surveyor then asked medication cart whe stated that he should	15, the surveyor asked LPN e medication cart from the le he was administering tated that he could not. It is the should lock the n he could not see it and he d. Surveyor then asked LPN he cart and he stated that he					
	08/26/15 at approxir	th the administrative staff on nately 1130, the concern of being left unlocked was ation.					
	surveyor with a copy Guidelines for Medic This policy read in pa	f nursing) provided the of the policy "General ation Storage" on 08/27/15. art "Medication rooms, cart, blies are locked or attended orized access".					
	The concern of the u	nlocked medication cart was					

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discussed with the administrative staff on

Event ID: SJD111

Facility ID: VA0406

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	·,		OMB NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER-	1	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		495409	B WING_	**************************************	C 08/27/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	
ABINGD	ON HEALTH CARE LL	r c	1	15051 HARMONY HILLS LANE	
/ / / / / / / / / / / / / / / / / / /	ON HEAGHT OAKE GE			ABINGDON, VA 24212	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLÉTION BE APPROPRIATE OATE
F 431	Continued From pa	ige 23	F 43	31	
	08/27/15 at approxi				
		ion was provided prior to exit. I CONTROL, PREVENT	F 44	41	
	The facility must es	tablish and maintain an		Corrective Action:	İ
	Infection Control Prosafe, sanitary and complete to help prevent the confidence of disease and infection Control The facility must est Program under which	rogram designed to provide a comfortable environment and development and transmission ction. I Program tablish an Infection Control ch it -		LPN #5 was educated control policy and pro washing during medic pour. LPN#5 was provalternative hypoallerg agent for use.	cedure for hand ation pass and vided an
	in the facility;	ntrols, and prevents infections		Other potential reside	ents:
	should be applied to	rocedures, such as isolation, o an individual resident; and ord of incidents and corrective fections.		Any resident has the p affected if infection co	otential to be
				procedure is not adher correct hand-washing t during medication pass	techniques
	isolate the resident.	•		Systemic changes:	
	communicable disea from direct contact w direct contact will tra (3) The facility must	require staff to wash their ect resident contact for which icated by accepted		Licensed nurses will be infection control policy for hand-washing durin pass and pour, and the any sensitivities to facilian alternative can be prinfection control practic	and procedure g medication need to report ity products so rovided and
	• •	die store process and		and the second of practice	.es maintained

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Event ID; SJDI11

Facility ID: VA0406

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PRINTED: 09/16/2015

CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES				FORM APPROVED MB NO. 0938-039
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495409	B. WING			C 08/27/2015
NAME OF	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/21/20/0
AB)NGD	OON HEALTH CARE LL				051 HARMONY HILLS LANE BINGDON, VA 24212	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RE COMPLETION
F 441		ige 24 as to prevent the spread of	F 44	41	Monitoring:	
	by: Based on observatifacility staff failed to and procedure for himedication pass and The findings include: A medication pass a conducted on 8/26/1 member LPN#5. LPN#5 was observer resident administer transluded an injection the chest area of the LPN#5 was then observed administer or and administe	and pour observation was 15 at 8:15 a.m. with staff ed to pour medications for a them. The medications and application of a patch to e resident. served to return to the proceeded to prepare and ications to another resident. If the medications and ication cart. LPN#5 was hy she failed to wash her			Unit Managers or designee will random hand washing audits du medication pass and pour of nu alternative shifts daily (M-F) for weeks, weekly for 4 weeks and for 1 week. Evidence of non-corwill be addressed and results we reported to QA for further discuand recommendations. This plan will be effective on Oct 2015.	uring urses on r 4 monthly mpliance rill be ussion
	recently switched to an alcohol prep pad	use. LPN#5 stated she used to wash hands between admitted she had not done				

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The assistant director of nursing was asked for

Eveni IO: SJDI11

Facility ID: VA0406

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/16/2015 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	,,		OMB NC	0.0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	I .	TIPLE CONSTRUCTION DING	(X3) DA	TE SURVEY MPLETED
		495409	B WING		ng.	C / 27/2 015
NAME OF	PROVIOER OR SUPPLIER		<u>'</u> -	STREET ADDRESS, CITY, STATE, ZIP CO		72772015
ABINGD	ON HEALTH CARE LI	.c		15051 HARMONY HILLS LANE		
	CLIMATE CTA	TEMENT OF SECONDARIAN	<u>l</u>	ABINGDON, VA 24212		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDEO BY FULL SC IDENTIFYING INFORMATION)	ID PREFI; TAG		SHOULD BE	(X5) COMPLETION DATE
F 441	Continued From pa	ge 25	F4	141		
	the facility policy on provided a copy. T policy stated "times	hand washing on 8/26/15 and ne facility Hand Washing when hand washing is very , "before and after resident				
F 502	director of nursing,	•	F 5	.02		
SS=D	2	•	ГЭ	Corrective Action:		
	The facility must provide or obtain laboratory services to meet the needs of its residents. The					
	facility is responsible of the services.	e for the quality and timeliness		Resident #6 had no ill eff		
	O. 1.10 OO. 1.1000.			PT/INR that was not obta #6's attending physician		1 1
	This RECHIREMEN	IT is not met as evidenced		that the 4/20/15 PT/INR		
	by:			obtained as ordered.		
	Based on staff interview and clinical record review, the facility staff failed to obtain a physician ordered laboratory test for 1 of 28 residents			Other potential resident	ts:	
	(Resident #6).			Any resident has the pot	ential to be	
	The findings include			affected if ordered labs a obtained.	are not	
	The facility staff faile Resident #6 on 4/20	d to obtain a PT/INR for /15.		Systemic Changes:		
	8/25/15 and 8/26/15 to the facility 3/3/15 but not limited to dw pressure ulcer sacrupulmonary disease,	f Resident #6 was reviewed Resident #6 was admitted with diagnoses that included arfism, paraplegia, stage 4 m, chronic obstructive neuromuscular bladder pulmonary embolus, chronic ong term use of		Licensed nurses will be e procedure for obtaining		!

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Event ID: SJDI11

Facility ID: VA0406

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PRINTED: 09/16/2015 FDRM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			<u>OMB NO. (</u>	0938-0391
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING	(X3) OATE COMP	SURVEY LETEO
		495409	B. WING		C	
NAME OF	PROVIDER OR SUPPLIER	-700-700	1	STREET ADDRESS, CITY, STATE, ZIP COOE	[08/2	7/2015
117.111.	NO VIDEN ON OUT FIELD			15051 HARMONY HILLS LANE		
ABINGD	ON HEALTH CARE LI	_C		ABINGDON, VA 24212		
(X4) I O PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION!	IO PREFI TAG		LD BE	(X5) COMPLETION DATE
F 502	Continued From pa	ge 26	F 5	502		
	anticoagulants, and	_				
		, posteros		Monitoring:		
	Resident #6's quart	erly minimum data set (MDS)		_		
		n assessment reference date		Unit Managers, Nursing Super	visors or	
		sessed the resident with a		designee will audit the clinical	record	
	cognitive summary	score of 15 out of 15.		for residents with PT/INR orde		
	The clinical record	contained a scanned physician		(M-F) for 4 weeks, weekly for		1
		that read "1) INR today. 2) v				
		change) Promethazine 25 mg		and monthly for 1 month to en		
	1/2 tab (tablet) po (by	y mouth) q (every) 6 ° (hours)		laboratory test is obtained as		
	prn (whenever nece	essary) nausea."		Evidence of non-compliance w	ill be	
				addressed and results will be r	eported	
		wed the electronic clinical		to QA for further discussion ar	•	
		ind 8/26/15 and was unable to yresults. The surveyor		recommendations.		
		stance of licensed practical		recommendations.		:
		he results of the PT/INR		Completion date October 8, 20)15.	. 1
	ordered to be done	on 4/20/15.		, , , , , , , , , , , , , , , , , , , ,		
	L D N #2 rovioused	the clinical record, called the				
		ory and stated there were no				
		ratory test on that day 4/20/15.				
		,				
		ned the administrator, the				
		the assistant director of				
		rporate registered nurse of the				
	above finding on 8/2	26/15 at 4:30 p.m.		•		1
	No further information	on was provided prior to the				
	exit conference on 8					
F 514	483.75(I)(1) RES	<i>5,2,,,</i> (6.	F 5	14		
SS≒F	RECORDS-COMPL	ETE/ACCURATE/ACCESSIB	, 5	1.1		
	LE					
	The facility must ma	aintain clinical records on each				
	resident in accordar	nce with accepted professional				
	standards and pract	tices that are complete;				1

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Event 10: SJ0] 11

Facility IO: VA0406

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OCT 02 2015 VDH/OLC

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/16/2015 FORM APPROVED OMB NO. 0938-0391

& MEDICAID SEKAICES			OMB NO. 0938-039
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED
495409	B WING_		C 08/27/2015
		STREET ADDRESS, CITY, STATE, ZIP CODE	
ABINGDON HEALTH CARE LLC		15051 HARMONY HILLS LANE ABINGDON, VA 24212	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
		DEFICIENCY)	
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 495409 C TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 495409 B WING C TEMENT OF DEFICIENCIES ID PREFIX	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 495409 B WING STREET ADDRESS, CITY, STATE, ZIP CODE 15051 HARMONY HILLS LANE ABINGDON, VA 24212 FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION) K2) MULTIPLE CONSTRUCTION B WING STREET ADDRESS, CITY, STATE, ZIP CODE 15051 HARMONY HILLS LANE ABINGDON, VA 24212 FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION) K2) MULTIPLE CONSTRUCTION FREET ADDRESS, CITY, STATE, ZIP CODE 15061 HARMONY HILLS LANE ABINGDON, VA 24212 FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION) K3) K400 MULTIPLE CONSTRUCTION A BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE 15061 HARMONY HILLS LANE ABINGDON, VA 24212

F 514 Continued From page 27

accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:

Based on staff interview and clinical record review the facility staff failed to ensure a complete and accurate clinical record for 3 of 28 Residents, Resident #12, #17, and #23.

The findings included.

1. For Resident #12, the Resident received cyanocobalamin (B12) one time a month. The physician ordered the medication to be given every month on the 18th. However the eMAR (electronic medication administration record) had the administration dates marked for the beginning of the month for June, July, and August.

Resident #12 was admitted to the facility 02/25/13. Diagnoses included, but were not limited to, dementia, congestive heart failure, psychosis, hypertension, insomnia, and dysphagia.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 05/27/15 was coded 1/1/3 to indicate the Resident had problems with long and short term

F 514

Corrective Action:

Resident #12's Cyanocobalamin (B12) order was updated in the eMAR to accurately reflect the monthly administration. Resident #17 received no ill effects from failure to document use of skin prep and Heelzup device. Resident #23 was a closed record review. Hospice notes for services provided to Resident #23 during her stay were obtained and scanned into the closed record.

Other potential residents:

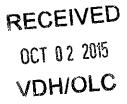
Any resident has the potential to be affected if the clinical record is not maintained completely and accurately. A 100% audit of clinical records for residents with B12 orders will be completed to ensure order entry accuracy and documentation of administration. A 100% audit of TARs for residents with skin prep and Heelzup device orders will be completed to ensure accuracy and complete documentation of administration. A 100% audit of clinical records for residents receiving Hospice services will be completed to ensure presence of admission agreement, physician order and hospice notes.

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Event ID: SJD(11

Facility ID: VA0406

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495409	B WING		C
NAME OF	PROVIDER OR SUPPLIER	430403	1 71	STREET ADDRESS, CITY, STATE, ZIP COL	08/27/2015
	ON HEALTH CARE LI	LC		15051 HARMONY HILLS LANE ABINGDON, VA 24212	<i>.</i>
(X41 ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	TOULD BE COMPLETION
F 514	skills for daily decise. The Residents clinic Summary Report of the ENP (family nurse programmer or summary reprogrammer or summary reprogrammer or summary reprogrammer. Injustification on the 18th. A review of the eM/2015 indicated that administered on Justification of Justification of the ending of the ending documentation. LPI surveyor it would popure and only the medication of the administrator, Injustification of the administrator, Injustification of the ending of the end of the ending of the end of t	everely impaired in cognitive	F 5	Systemic changes: Licensed nurses will be eduted documentation requirement complete and accurate methics will be eduted reviewing the electronic heto Dashboard daily at change all required MAR and TAR docomplete. Monitoring: Unit managers, Supervisors, designee will monitor reside and hospice records daily for weekly for 4 weeks, and the month. Evidence of non-cordidatessed and results report committee. This plan will be effective or	nts to maintain a dical record. Icated on alth record of shift to ensure locumentation is staff RN's, or ent MAR/TAR/ or 4 weeks, en monthly for 1 mpliance will be red to QA
	No further informati provided to the survicenterence. 2. For Resident #17 failed to document of	on regarding this issue was vey team prior to the exit 7, the facility nursing staff on the eTAR (electronic ation record) for the		2015.	•

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device.

administration of skin prep and use of the heelzup

Event ID: SJDI11

Facility ID: VA0406

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PRINTED: 09/16/2015

CENTERS FO	OR MEDICAR	E & MEDICAID SERVICES			0		. 0938-0391
STATEMENT OF DE AND PLAN OF COF	EFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		E CONSTRUCTION	(X3) DAT	E SURVEY MPLETED
		495409	B. WING _				C /27/2015
NAME OF PROVI	DER OR SUPPLIER		1		TREET ADDRESS. CITY, STATE, ZIP CODE	1	<u> </u>
ABINGDON HI	EALTH CARE LI				5051 HARMONY HILLS LANE BINGDON, VA 24212		
	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	· ·	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
Resingular sections of the Resingular sections o	28/12. Diagnose ted to, demential tety. Ition C (cognitive rterly MDS (min an ARD (asses 18/15 scored the points. Residents clinic prep to bilateral elzup device to ras tolerated. eview of the eTA the facility nurs. In day shift. 18/26/15 at apple eyor and LPN (language) and LPN (language) and the facility had administer 20, and 24. The heelzup deviated to visualize the bed with the ident refused to visualize the heels well dent did not have administrator, EN (assistant dir sterly desistant dir second contractions).	admitted to the facility es included, but were not a, epilepsy, hypertension, and re patterns) of the Residents nimum data set) assessment ssment reference date) of e Resident 3 out of a possible ical record included an "Order that included orders to "Apply al heels, every day shiff" and use while in bed or reclining	F 51	14			
docu heelz on 08	imentation rega zup device in a 8/26/15 at appro	arding the skin prep and meeting with the survey team roximately 11:30 a.m. on regarding this issue was					

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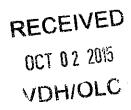
conference.

provided to the survey team prior to the exit

Even(ID: SJDI11

Facility ID: VA0406

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PRINTED: 09/16/2015 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		C	MB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495409	B. WING		C 08/27/2015
NAME OF	NAME OF PROVIDER OR SUPPLIER		<u>'</u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/27/2015
ABINGD	ON HEALTH CARE LI	LC		15051 HARMONY HILLS LANE ABINGDON, VA 24212	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	D BE COMPLETION
F 514	Continued From pa	ige 30	F S	i14	
	#23's electronic me and accurate. The not reveal any hosp	failed to ensure Resident edical record was complete electronic medical record did pice documentation related to ent, physician orders, and			
	The clinical record of Resident #23 was reviewed 8/26/15 and 8/27/15. Resident #23 was admitted to the facility initially 12/29/14 and readmitted 5/1/15. Resident #23's diagnoses included but were not limited to debility, atrial fibrillation, chronic kidney disease, diabetes mellitus, acute pain, pressure ulcer, edema, hyperlipidemia, hypertension, esophageal reflux, and anxiety. Resident #23's significant change in assessment minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/14/15 coded the resident with a brief interview for mental status (BIMS) as 14 out of 15.				
	Resident #23 was a	admitted to hospice on 5/1/15.			

The surveyor interviewed the corporate registered nurse on 8/26/15 at 4:00 p.m. and was informed that hospice notes should be under the "Miscellaneous" tab on the computer. The electronic medical record revealed three documented pages that Resident #23 had hospice: orders dated 5/1/15 for hospice admission, a two page scanned med list dated 5/27/15 and a form titled "Witness of Removal of Human Remains" dated 6/18/15. The electronic medical record contained no admission contract, admission physician orders, or hospice notes.

Medical records other #7 was interviewed on 8/27/15 at 8:00 a.m. if she had hospice information that had not been scanned into the computer for Resident #23. She stated she didn't

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PRINTED: 09/16/2015 FORM APPROVED OMB NO. 0938-0391

CENTE	KS FOR MEDICARE	: & MEDICAID SERVICES			C	MB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTIOI	N		SURVEY PLETED
		495409	B. WING			08/2	27/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS.	CITY, STATE, ZIP CODE	1	
ABINGD	ON HEALTH CARE LI	.c	<u> </u> 	15051 HARMONY ABINGDON, VA	HILLS LANE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVII (EACH CC	DER'S PLAN OF CORRECTIO DRRECTIVE ACTION SHOULD FERENCED TO THE APPROP DEFICIENCY)) BE	IX5I COMPLETION DATE
F 514	the surveyor looked from the hospice ag skilled unit and four #23's hospice notes would check with the unit when she arrived. The surveyor asked if the hospice notes informed the surveyor were being faxed to the surveyor information of nursing, nurse, and the corpabove finding on 8/2 During the meeting, director of nursing if to be available now Resident #23 had endedd "yes." Residue the facility.	Medical records other #7 and I for paper documentation gency for Resident #23 on the Ind no "notebook" for Resident Islorders. She stated she e unit secretary for the skilled ed for work. If the medical records other #7 had been found and she for that the hospice notes of the facility now. The administrator, the state regional minimum data set for the surveyor asked the is she would expect the notes rather than two months after expired in the facility and she dent #23 expired 6/18/15 in the surveyor documents after than two months after expired in the facility and she dent #23 expired 6/18/15 in the surveyor to the surveyor to the second of the secon	F 5				

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Event ID: SJDI11

Facility ID: VA0406

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STATEMENT OF ISOLATED DEFICIENCIES WHICH CALISE NO HARM WITH ONLY A POTENTIAL FOR MINIMALFIARM FOR SNELAND NES	PROVIDER # 495409	MILITURE CONSTRUCTION A HUBLING B WING	DATE SURVEY L'HMPLETE 8/27/2015				
NAME OF PROVIDER OR SUPPLIER ABINGDON HEALTH CARE LLC		S. CITY, STATE, ZID CODE PNY HILLS LANE 'A	:				
D PREFIX FAG STIMMARY STATEMENT OF DEFICIEN	TIENCHES						
The resident has the right to personal personal privacy includes accommodat personal care, visits, and meetings of la provide a private room for each resident Except as provided in paragraph (e)(3) personal and clinical records to any ind The resident's right to refuse release of transferred to another health care institut. The facility must keep confidential all i or storage methods, except when release party payment contract, or the resident. This REQUIREMENT is not met as even based on observation, staff interview and healthcare information for 2 of 28 Resident findings included: 1. For Resident #27, the facility staff fair private healthcare information during a resident #27 was admitted to the facility anxiety and dysphagia. The most recent MDS (minimum data sease Resident as 0 of 15 in section C. cognition on 08/26/15 at approximately 0810, dur LPN #1 walking away from the medicat computer screen contained private health on 08/26/15 at approximately 0825, the when he walked away, and he stated that screen and he stated that he should have.	rivacy and confident ions, medical treat imily and resident in. of this section, the ividual outside the ividual outside the personal and clinication; or record relation; or record relation pass and facility docume lents. Resident #27. led to close/cover medication pass and y on 01/21/15. Diated with and ARD (we patterns. ing a medication pass and patterns.	entiality of his or her personal and cliniment, written and telephone communic groups but this does not require the factories but this does not require the factories are resident may approve or refuse the relectacility. In the residents records are gardless to another healthcare institution and the residents records, regardless that the review, the facility staff failed to provious and #28. The computer screen containing the Resident pour observation gnoses included but not limited to demonstrate the facility staff failed to provious assessment reference date) of 08/15/15 pass and pour observation, the surveyore computer screen open and uncovered for Resident #27.	eations cility to ease of sident is of the form law; third tect private sidents entia coded the observed The				

Any deficiency statement ending with an asterisk *I denotes a deficiency which the institution may be excused from currecting providing it is determined that other safeguards provide sfferein protection in the patients. (See institutions.) Except for nursing houses the findings stated adure are disclassible/0 days following the date of survey, whether or not a plan of entreetion is provided For nursing houses the almost findings and plans of correction are disclassible/14 days following the date these discussions are made as adult to the facility. If deficiencies are cited an approved plans of

The obuve isulated deficiencies pase in actual harm to the residents

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OCT 0.2 2015 If cuntinuation sheet 1 of 3

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	MEDICARE & MEDICATO SERVI.	

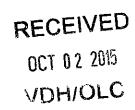
IIA Macon par

	T OF ISLICATED DEFICIENCIES WHICH CAUSE WITH LINLY A PITTENTIAL FUR MINIMAL HARM	PRIJVIDER #	MILTHELEURISTRUCTION A BUILDING	DATE SURVEY					
FDR SNFs A	NI) NF ₈	495409	fi wini:	8/27/2015					
NAME OF PROVIDER OR SUPPLIER ABINGDON HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIPCLIDE 15051 HARMONY HILLS LANE ABINGDON, VA							
ID PREFIX TAG	SUMMARY STATEMENT LIF DEFICIE	ENCIES							
F 164	Continued Ernii Prige t On 08/26/15 at approximately 1130 during a meeting with the administrative staff, the incident was brought to their attention. On 08/27/15 at 0830, the DON (director of nursing) provided the surveyor with a copy of the lacility policy on "Privacy and Confidentiality". The policy read in part "recognizes the following is protected health information per the Privacy Rule: Individually identifiable health information including demographic information" and "Limit computer access to PHI (prutected health information) by using password protection and automatic screensavers that require password entry to reopen screeif. During a final meeting with the administrative staff on 08/27/15 at approximately 0915, the incident was discussed. No further information was provided prior to exit 2. For Resident #28, the facility staff failed to close/cover the computer screen containing the Resident's private healthcare information during a medication pass and pour observation Resident #28 was admitted to the facility on 12/02/13 and readmitted on 02/28/15. Diagnoses included but not limited to hypertension, hyperlipidemia, cardiovascular accident, dementia anxiety, depression, psychotic disorder, clironic obstructive pulmonary disease, and gastroesophageal reflux disease.								
	The most recent quarterly MDS (minime coded the Resident as 7 of 15 in section On 08/26/15 at approximately 0800, du LPN #1 walking away from the medical computer screen contained private heal On 08/26/15 at approximately 0825, the when he walked away, and he stated that screen and he stated that he should have On 08/26/15 at approximately 1130 duratheir attention. On 08/27/15 at 0830, the DON (director on "Privacy and Confidentiality", The prinformation per the Privacy Rule: Indivinformation" and "Limit computer according to the protection and automatic screensavers the code of the	or C, cognitive patternation of a medication patternation cart leaving the theare information for the surveyor asked LP at he had not Surveye. The formula meeting with the rof nursing provides to patternation part " Tidually identifiable teess to PHI (protecte hat require passwore)	ass and pour observation, the surveyor computer screen open and uncovered or Resident #28. N #1 if he had closed/covered the compor asked him if he should have closed the administrative staff, the incident was the detection of the facilities of the surveyor with a copy of the facilities of the faci	observed I The puter screen /covered the is brought to lity policy health phic					
	During a final meeting with the adminis discussed. No further information was p	strative staff on 08./27 provided prior to exi	7/15 at approximately 0915, the incide t	nt was					

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Even ID: SJDH t

If continuous sheet 2 of 3



DEPARTMENT OF HEALTH A	ND HUMAN SEI $^{\prime}$ $^{+1}$	ES
TENTERS FOR MEDICARE &	MEDICAID SERVE, T	. (

AH "A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE		PROVIDER #	MIELTIPLE CONSTRUCTION	DATE SURVEY
NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM			A BUILDING	COMPLETE
FOR SNESAND NES		495409	B WING	8/27/2015
NAME OF PROVIDER OR SUPPLIER ABINGDON HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIPCODE 15051 HARMONY HILLS LANE ABINGDON, VA		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICE	ENCIES		
1			Corrective Action:	
		LPN#1 was provided education on the Privacy and Confidentiality policy		ion on the
			Other potential residents:	
			All residents have the poter affected if computer screen closed or covered during me pass and pour.	s are not
			Systemic Changes:	
			Licensed nurses will be educe Privacy and Confidentiality princludes closing or covering screen during medication papour.	oolicy that the eMAR
			Monitoring:	
			Unit Managers, Supervisors, will monitor 2 medication paweek times 4 weeks, then 1 for 2 weeks, then monthly for months. Evidence of non-cowill be addressed and results to QA committee.	esses per per week or 1 mpliance
			This plan will be effective on 2015.	October 8,
1)1099				1

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